MenHibrix® Order Form

MenHibrix® (Hib-MenCY-TT) vaccine is currently available from the Idaho Immunization Program in limited quantities and only to infants at increased risk for meningococcal disease, which includes:

- Infants with recognized persistent complement pathway deficiencies, and
- Infants who have anatomic or functional asplenia including sickle cell disease.

Please note that the MenHibrix® vaccine does not meet the requirement for international travel to the "meningitis belt," and the quadrivalent MCV4 vaccine should be used to meet that requirement.

Based on an assessment of the potential public health impact, including the current low incidence of meningococcal disease in the United States, at this time Advisory Committee on Immunization Practices (ACIP) does not recommend routine meningococcal vaccination for infants who are *not* at increased risk for meningococcal disease (for additional information go to http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6203a3.htm).

MenHibrix® is currently available in single dose distribution only. MenHibrix® is part of a four-dose series for infants aged 6 weeks through 18 months of age, and replaces the Hib vaccine.

This order form is for MenHibrix® vaccine only. If you would like to place an order for additional vaccine or vaccines other than MenHibrix®, then please do so by logging into Idaho's Immunization Reminder Information System (IRIS).

To place an order for MenHibrix® please complete and return this form to the Idaho Immunization Program (IIP) by fax (208.334.4914), email (IIP@dhw.idaho.gov), or standard mail (see address below).

Organization Name: _____ VFC Pin: _____

Ordered by: _____ Date: _____

Please indicate which high-risk condition below is applicable to the patient:

- ☐ Persistent complement pathway deficiency
- ☐ Anatomic or functional asplenia

Patient's Date of Birth: _____ / _____ / _____
MM DD YYYY

Circle the dose number in the series that you are ordering: 1 2 3 4

Please indicate the eligibility of the patient. If the patient is eligible for the federal Vaccines for Children (VFC) program, then please include which criteria is met:

- ☐ Not VFC-eligible
- ☐ VFC-eligible
  - ☐ Is a Native American or Alaska Native,
  - ☐ Is enrolled in Medicaid,
  - ☐ Has no health insurance, or
  - ☐ Is underinsured (has health insurance, but the coverage does not include vaccine; eligible at a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or local public health department).

Physician Name (please print): _____

Physician Signature: _____ Date: _____

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IDAHO IMMUNIZATION PROGRAM
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